STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Bronson Commons was surveyed for an Abbreviated and Recertification survey on 6/10/25 - 6/12/25. Intakes: MI00151630 Census: 85	F0000		
F0554 SS= D	Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure residents were assessed to be appropriate for self-administration of medications for 3 (Resident #65, Resident #272, and Resident #13) of 3 residents reviewed for self-administration of medications resulting in medications being left unsecured at resident's bedside, residents self-administering medications without staff assessment, and the potential for negative outcomes from taking/applying/instilling too much or too little medications. Findings include: Resident #65 Review of a "Facesheet" revealed Resident #65 was a female who was admitted to the facility on 5/14/2025 with pertinent diagnoses which included: Gastroparesis (slow or stopped gastro motility) and dependence for cares.	F0554	1. One of the three residents was found to have medications in their possession. This was retrieved and locked up. Education was provided to residents and assigned nurses regarding self-administration of medication and expectations related to protocol. One affected resident has discharged from the facility. The other two will be assessed for their ability to self-administer medications safely per policy. 2. Any resident has potential to be affected. 3. Education will be provided to admission staff related to self-administration of medication policy, to include asking if the resident has any kind of over the counter or prescribed medication in their possession, and explaining expectations related to this policy. Specified scripting will be provided. Education will be refreshed with nursing employees related to the existing self-administration policy. It will be added to new hire orientation checklist for new employee education. An additional step will be added to the new admission checklist to include a discussion with the nurse and resident regarding the self-administration policy. Nurses will be instructed	7/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a "Minimum Data Set" (MDS) assessment for Resident #65, with a reference date of 5/20/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 12/15 which indicated Resident #65 was cognitively intact. During an observation and interview on 6/11/25 at 2:30 pm, Resident #65 retrieved a green in color bottle of eye drops from her bedside table and instilled drops into each eye independently. When queried, Resident #65 stated the drops were hers, for her "dry eyes", she did them herself when she needed them. Review of "Order Summary" for Resident #65 revealed no order noted for any eye drops. In an interview on 6/12/25 at 10:03 am, "Unit Coordinator" (UC) "R" reported all eye drops required a physician order, including any over the counter drops. UC "R" reported that no resident's had orders to self-administer medications. UC "R" reviewed Resident #65's medical record and confirmed that Resident #65 did not have a physician order for any eye drops, did not have a completed assessment for self-administration of medications, and did not have an order to self-administer medications. In an interview and observation on 6/12/25 at 2:10 pm, "Licensed Practical Nurse" (LPN) "JJ" reported that a physician order was required for a resident to receive eye drops, even if they were over the counter and not prescription. LPN "JJ" reported that the facility had over the counter artificial tears available for residents and demonstrated a bottle white/clear in color. In an interview on 6/12/25 at 2:10 pm, "Registered Nurse" (RN) "II" reported Resident #65 did not have an order for eye drops and that she was aware Resident #65 had eye drops in her		to include a comment in Admission Navigator Section of the EMR to reflect that the conversation was completed. The Self Administration of Medication policy was updated to include an explanation to residents upon admission related to the policy and its expectations Five weekly audits will be completed of admission documents and nursing assessments to ensure the policy is discussed as expected for the next 12 weeks. Five verbal weekly audits will also be completed with nurses to seek their understanding of the policy for the next 12 weeks. The Executive Director is responsible for compliance with this policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room. RN "II" reported that Resident #65 did not have an assessment to self-administer medications, and that Resident #65 would not be a good candidate to self-administer medications due to her history of having to have unauthorized items removed from her bedside. RN "II" reported that today was the first time she had ever seen Resident #65 with a bottle of eye drops, but it was not the first times she had to remove medications from Resident #65's bedside. Resident #272 Review of a "Facesheet" revealed Resident #272 was a female who was admitted to the facility on 5/23/2025 with pertinent diagnoses which included: end stage kidney disease (kidneys no longer function) and dependence on dialysis (a blood filtration process due to the lack of kidney function). Review of a "Minimum Data Set" (MDS) assessment for Resident #272, with a reference date of 5/29/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 12/15 which indicated Resident #272 was cognitively intact. In an interview on 6/10/25 at 2:52 pm, Resident #272 reported it was easier when the nurse left her chewable tablet (Fosrenal 1000mg) with her so she could take it when she was done eating. Resident #272 reported that some nurses left it, and some nurses did not leave it. Resident #272 reported that she should eat her chewable tablet immediately after she was done eating a meal. Review of "Order Summary" for Resident #272 revealed " ... Lanthanum (Fosrenal) chewable tablet 1000 mg (milligrams) one po (by mouth) with meals ..." (Fosrenal- a chewable tablet that binds with phosphate in the body to allow for the body to absorb calcium, a lack of calcium			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	absorption can lead to a very serious medical complication. Fosrenal should be taken with food or immediately after a meal). In an interview on 6/11/25 at 11am, Resident #272 reported she wanted the facility to be consistent with her medications. Resident #272 reported she would like the nurses to leave her chewable tablet with her meals so she could take it when she was done eating, but some nurses left it, and others returned after her meal was finished to give it to her. Resident #272 reported she would like consistency with her medications. In an interview on 6/11/25 at 11:15 am, RN "II" reported that the nurses do leave Resident #272's Fosrenal chewable tablet at the bedside when she had her meal. RN "II" reported that Resident #272 was not assessed for self-administration of medications and that the facility does not allow for self-administration of medications. RN "II" reported that she does leave Resident #272's Fosrenal at her bedside when she has her meal because "she knows she will take it". RN "II" reported that Resident #272 would be appropriate to self-administer medications. Resident #13 Review of an "Admission Record" revealed Resident #13 was originally admitted to the facility on 5/1/24 with pertinent diagnoses which included: cancer, heart failure (chronic condition in which the heart does not pump blood as well as it should), anxiety and depression (persistent depressed mood or loss of interest in activities causing significant impairment in daily life). Review of a "Minimum Data Set" (MDS) assessment for Resident #13 with a reference date of 4/26/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #13 was cognitively intact. Section "N" of the MDS revealed Resident #13 received antianxiety, antidepressant, a diuretic (drug that causes the kidneys to make more urine) and opioid (class of drug used to reduce moderate to severe pain) medications. Review of a "Care Plan" for Resident #13 with a reference date of 5/14/24, revealed a problem/goal/interventions of: "Problem: I use my medication to help me manage my diagnosis. I want to avoid any potential drug related complications. Goal: I would like to remain free of drug related complications. Interventions: ...monitor me for side effects of my medication ...". In an interview on 6/10/25, at 12:48pm, Resident #13 reported the nurses sometimes left her medications for her to take on her own. Resident #13 reported earlier on 6/10/25, when she dropped one pill on the floor and no staff were present, she almost attempted to pick up on her own but then remembered she had previously fallen out of her chair when she tried to pick something up from the floor. Review of "Physician Orders" for Resident #13 with a reference date of 5/1/24-present, revealed no orders for nurses to allow the resident to self-administer any medications. In an interview on 6/10/25 at 10:26am, Registered Nurse (RN) "K" reported no residents on Resident#13's unit had been assessed as able to self-administer medications. In an interview on 6/11/25 at 11:53am, Resident #13 reported she thought the nurse's usually just left her supplements and vitamins for her to take on her own. Resident #13 reported in addition to other prescribed medications, she was prescribed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a supplement for arthritis (swelling and tenderness in the joints) and a vitamin C tablet. In an interview on 6/11/25 at 3:46pm, Licensed Practical Nurse (LPN) "HHH" reported no residents on Resident #13's unit had been assessed as able to self-administer medications. Review of an emailed response from Nursing Home Administrator (NHA) "A" with a reference date of 6/12/25 at 9:18am, revealed: "We do not have self-administration screens(assessments) for these patients (Resident #65, Resident #272, and Resident #13)". Review of a "Self-Administration and Completion of Medication Administration" policy with no reference date, revealed "POLICY: Applies to any resident who wishes to self-administer medication or complete medication administration without direct visual supervision ...Procedure: ...2) If the resident wishes to pursue this offer (self-administration), an assessment must be completed ...5) If deemed safe, a provider order will be placed in the electronic medical record indicating the resident may self-administer or that medications prepared by the nurse may be left with the resident to complete administration without direct visual supervision ...7) a MAR (Medication Administration Record) Note will be added to the resident's MAR that highlights the resident has an order to self-administer or that medications prepared by the nurse may be left with the resident ...".			
F0561 SS= D	Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1)	F0561	1. A care conference will be scheduled with the Interdisciplinary Team (IDT) and resident to identify preferences and discuss how the facility can best meet resident's needs. Care plan will then be updated to reflect the discussion.	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure activities of daily living (ADL) cares and assistance were provided per resident preference for 1 (Residents #17) of 2 residents reviewed for resident preferences, resulting in dissatisfaction with care and the potential for decline in sense of physical, mental, and psychosocial well-being. Findings include: Review of a "Minimum Data Set" (MDS) assessment for Resident #17, with a reference date of 4/18/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #17 was cognitively intact. Review of the "Functional Abilities" revealed that Resident #17 was dependent for toileting and transfers.		2. All residents have the potential to be affected. 3. Existing "Interdisciplinary Long-Term Care Resident Review Protocol" was updated to include : Resident and/or resident representative interview should include a discussion about care preferences and will be completed by a member of the IDT. Standard care preference questions should include the following: toileting, sleep and wake preferences, meals, and other care preferences the resident would like to share." With this information care plans will be updated at least quarterly with resident and/or representative input and subsequently implemented into how their care is provided. 3. Bi-weekly longterm care resident review meetings will include an audit of all residents due for quarterly review to ensure that interviews were completed and identified preferences were implemented into the care plan for at least the next 12 weeks. 4. The Executive Director is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 06/10/25 at 10:57 AM, Resident #17 reported that she had moved rooms so that she could had access to a ceiling mechanical lift that would allow her to transfer easier. Resident #17 reported that staff tell her that she cannot use the commode every time she has to use the bathroom, because it takes too much of their time. Resident #17 reported that especially at night and during mealtimes, staff offer the bedpan instead of the bedside commode; the bedpan is uncomfortable and the resident prefers to use the commode. Resident #17 reported that she had tried to request the commode when she knew there were enough staff working. In an interview on 06/11/25 at 11:52 AM, Certified Nursing Assistant (CNA) "J" reported when there are enough staff, Resident #17 used the commode, but otherwise she used the bedpan. CNA "J" reported that Resident #17 did get upset about using the bedpan. In an interview on 06/11/25 at 12:07 PM, Licensed Practical Nurse (LPN) "JJ" reported that Resident #17 was not always happy with the care that she received, and that related to hoyer (mechanical) transfers staff had told her "we can't do this all day" in the past because of the amount of time it takes. In an interview on 06/11/25 at 02:16 PM, CNA "F" reported that Resident #17 used the commode for toileting, except for during meal times. CNA "F" reported that staff cannot stop passing trays and answering call lights to transfer the resident, unless they have extra staff. Review of Resident #17's "Care Plan" revealed, "Problem: I am incontinent of urine. Date Start: 04/24/25, Goal: I will be clean, dry and odor free...INTERVENTIONS: I need to be checked			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and changed routinely and as needed. Encourage me to verbalize the need to use the toilet. Please keep my call light in reach..." There was no preference noted for toileting. Review of Resident #17's "Kardex (CNA care guide)" revealed, "...Level of Assistance - 06/12/25 at 08:53 (AM) Toileting, Toilet type: Bedside commode; Brief Change; Incontinence pad..." Review of Resident #17's "Progress Note" dated 6/2/25 revealed, "Cognition/behaviors/mood: A &O (alert and oriented) x 4 but has herself c/o (complained of) memory deficits recently. At times has numerous requests for transfer to and from commode, but frequently is incontinent while being transferred (via overhead lift) while in transit to commode. During mealtimes a bedpan is offered as it requires too many staff off the floor to use mechanical lift...Bowel/bladder: Incontinent of bladder, bowel continence varies." Review of Resident #17's "Occupational Therapy (OT)" note dated 3/13/23 revealed, "...Toileting Comments: reports incontinent of urine at baseline; encouraged up to BSC (bed side commode) with nursing staff, as pt (patient) not appropriate for use of bedpan..."			
F0577 SS= C	Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of	F0577	1. The facility moved the binders containing survey results to a prominent location in the lobby on a table that residents, family members, and legal representatives can reach either standing or sitting in a wheelchair. The public binders include survey results for the current year and the previous 3 years along with plans of correction. The facility also placed a prominent notice at the table stating that survey and advocacy information is available here.	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the results of the most recent federal surveys and corresponding plans of correction were readily accessible to all residents in the facility, with a census of 85 residents, resulting in the residents not being informed of identified deficiencies and solutions as written in the plan of correction. Findings include: During a confidential group meeting on 06/11/25 at 10:34 AM, six of six residents reported that they were not aware they could read the survey reports; they did not know who to ask or where to find them. During an observation on 06/11/25 at 11:25 AM in the sitting area next to the main lobby there was a shelf hanging approximately 4-5 feet up on the wall containing a binder that housed survey reports. In an interview on 06/11/25 at 12:02 PM, Licensed Practical Nurse (LPN) "JJ" reported that		2. All residents who want this information have the potential to be affected. 3. The facility created the policy: Facility Required Postings. The facility created the flier "Where to Find Survey Reports" and will distribute it to all patients and residents. The flier will also be added to the facility admission packet. Education will be provided to all employees about where survey information can be found. The resident council will also be given this information at the July meeting. 4. During daily routine leadership rounds, each leader will interview at least one resident for awareness where to locate survey results, for at least the next 12 weeks. 5. The executive director is responsible for compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she did not know where to find the survey reports; and was not sure how residents were expected to get access to those. In an interview on 06/12/25 at 11:19 AM, Nursing Home Administrator (NHA) "A" reported that the survey reports were located in an area that residents do not frequent and were not easily accessible. In an interview on 06/12/25 at 02:53 PM, Activity Associate (AA) "U" reported that she conducts "resident council" meetings monthly but was not aware of how residents would obtain access to the survey reports.			
F0585 SS= E	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F0585	1. The facility moved concern/grievance forms to a table top location that is prominent and easily accessible in the lobby. A prominent notice was placed to guide residents to the location. 2. All residents who have concerns about their care have potential to be affected. 3. The facility created a log of concerns and grievances to monitor follow up and ensure each concern is resolved. The log also enables the facility to track and trend concerns to identify opportunities for continuous quality improvement. The facility will report the number and nature of concerns, resolution status, and trends at monthly Quality Assurance Performance Improvement (QAPI) meetings, where the QAPI Committee will use the information to direct performance improvement projects as warranted. The facility will also provide written information to all residents on the right to air	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance		concerns or grievances, and the location of self-reporting forms. This information will be provided to the Resident Council at the July meeting. Going forward, this information will also be included in the admission packet. Education will be provided to all employees about the right to air concerns and grievances, and how residents can submit concerns or grievances using forms that are available in the lobby or with confidential help from an employee. Education will include how these are tracked for continuous quality improvement. 4. During routine daily leadership rounds, each leader will interview at least one resident for awareness how to report a concern or grievance for at least the next 12 weeks. During monthly QAPI meetings the committee will review the number, nature and status of concerns and will determine if opportunities are present for performance improvement. 5. The executive director is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to inform residents and/or educate residents and effectively implement the grievance process for six of six residents from a confidential group meeting and all 85 residents that reside in the facility, resulting in the potential for residents to not meet their highest practicable level of wellbeing due to grievances not being documented, tracked, and the results of conclusions and/or resolutions not being recorded. Findings include: During a confidential group meeting on 06/11/25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 10:34 AM, six of six residents reported that they talked about the same concerns month after month in resident council meetings. These residents also reported that they were not aware that they could have their private concerns documented on a form, that staff could assist them to complete the form, and/or that they could complete a concern form anonymously. The residents did not know that there were forms available and reported that they would utilize the concern forms if they had access to them. During an observation on 06/11/25 at 11:25 AM in the sitting area next to the main lobby there was a shelf hanging approximately 4-5 feet up on the wall containing a binder that housed blank concern forms. In an interview on 06/11/25 at 12:02 PM, Licensed Practical Nurse (LPN) "JJ" reported that she did not know where to find concern forms for residents to submit their concerns; she did not assist residents with concern forms. LPN "JJ" reported that management handled resident concerns. In an interview on 06/11/25 at 01:59 PM, Activity Associate (AA) "AA" reported that she was not familiar with concern forms that residents could complete. In an interview on 06/12/25 at 11:19 AM, Nursing Home Administrator (NHA) "A" reported that the concern forms were located in an area that residents do not frequent and were not easily accessible. In an interview on 06/12/25 at 02:53 PM, Activity Associate (AA) "U" reported that she conducted "resident council" meetings monthly and emailed the group's concerns to the related departments but did not follow up to ensure the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	concerns were all addressed. AA "U" reported that during resident council meetings she discussed any responses from the previous month concerns. In an interview on 06/12/25 at 01:28 PM, Director of Nursing (DON) "B" reported that concern forms are available for residents in the lobby but they are out of the way and posted high on the wall. DON "B" reported that typically staff are the ones to initiate the concern form.			
F0605 SS= D	Right to be Free from Chemical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must	F0605	1. Medical records will be reviewed by providers and the Interdisciplinary Team (IDT) to determine the necessity of medication and frequency. Medications will be discontinued or frequency modified accordingly. 2. All residents have the potential to be affected. 3. EMR Reports will be utilized to identify those with orders for PRN psychotropic medications. Behavior Management Program Policy was updated to include: "When pharmacological interventions are utilized, the duration of order must meet regulatory requirements. PRN psychotropic medications should not exceed more than 14 days unless clinical documentation by a provider is present to provide rationale. Orders will be reviewed during the Behavioral Health Committee meeting to ensure pharmacological interventions meet criteria for use and regulatory requirements." Antipsychotic Medication Management policy was updated to include: "When pharmacological interventions are utilized, the duration of order must meet regulatory	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.		reuirements. PRN Psychotropic medications should not exceed more than 14 days unless clinical documentation by a provider is present to provide rationale." Education will be provided to nurses, providers and social services teams regarding policy updates and expectations. External partners providing pharmacy and behavioral health services will receive this refreshed education as well. Weekly Clinical Oversight meeting will monitor these medications utilizing EMR report on a weekly basis. 4. Behavioral Health Committee will review a report of all PRN psychotropic medications during monthly routine meetins to determine the necerssity of medication and appropriate frequency. Medications will be discontinued or frequency modified accordingly. Weekly Clnical Oversight meetings will monitor these medications utilizing EMR report on a weekly basis. Five weekly audits to ensure compliance will be completed by Social Services or designee utilizing EMR report for the next 12 weeks. The executive director is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to limit the duration of a PRN (as needed) psychotropic medication to 14 days and/or ensure the physician documented rationale to extend the duration of use for two (Resident #26 and Resident #17) out of five reviewed for unnecessary medications. Findings include: Resident #26 Review of an "Admission Record" revealed Resident #26 was originally admitted to the facility on 2/16/29 with pertinent diagnoses which included: alzheimer's disease (a progressive disease that primarily affects memory, thinking and behavior) and major depressive disorder (persistent sad mood that interferes with daily life). Review of a "Minimum Data Set" (MDS) assessment for Resident #26 with a reference date of 6/4/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 3/15 which indicated Resident #26 was severely cognitively impaired. Section "E" revealed Resident #26 had no behaviors during the 14-day assessment period. Review of a "Care Plan" for Resident #26 with a reference date of 9/25/19, revealed a problem/goal/interventions of: "Problem: Mood. Goal: I have changes in mood due to my medical diagnosis. I want negative symptoms to be manageable daily and through the next review. Interventions ...assess my mood on all review dates and as needed ...provide medications as ordered ...Monitor for increased signs or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms of depression and anxiety". Review of "Physician's Orders" for Resident #26 revealed a current order: "LORazepam tablet .25mg (milligrams) Every 8 hours PRN (as needed), Start: 5/30/25 1251 End: 6/29/25 1250". Review of a "Long Term Rounding-Progress Note" for Resident #26 written by a provider on 4/21/25, revealed "Assessment/Plan: ...17. Generalized anxiety disorder. Continue (Brand name omitted) LORazepam PRN-utilizes minimally ...Psychiatric/Behavioral: Positive for confusion. Negative for agitation. The patient is not nervous/anxious". Review of "Medication Administration Records" for Resident #26 revealed the resident did not receive any doses of LORazepam .25mg PRN from 4/13-6/12/25. In an interview on 6/11/25, at 11:06am, Social Services Coordinator (SSC) "L" reported Resident #26 received the order for LORazepam .25mg on 2/18/24 and it had been renewed several times. SSC "L" confirmed Resident #26 currently had an order for a PRN psychotropic medication that extended greater than 14 days. SSC "L" reported the use of psychotropic medications was monitored during a monthly "Behavioral Health" meeting and Resident #26's order for LORazepam could be added to the agenda. In an interview on 6/11/25 at 2:28pm, Unit Coordinator (UC) "DD" confirmed Resident #26 had a PRN order for a psychotropic medication that was greater than 14 days and this was not within compliance perimeters for this type of medication unless the provider documented a rationale for doing so. UC "DD" reported she would provide documentation of a provider's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rationale if it was made available. No additional documentation identifying the provider's rationale for extending a PRN psychotropic medication beyond 14 days for Resident #26 was provided by the conclusion of the survey. Resident #17 Review of Resident #17's "Physician Orders" revealed, "Lorazepam (Ativan) tablet 0.5 mg...Frequency: Daily as needed for anxiety...Duration: 30 days..Start Date/Time (after last modification): 5/19/25...End Date/Time: 6/18/25..." The most recent dose was given on 6/6/25 at 7:36 AM. An attempt to interview Medical Director (MD) "III" on 06/12/25 at 12:18 PM was made, with no return phone call prior to survey exit. This surveyor requested physician rationale for Resident #17's order for PRN (as needed) Lorazepam written for greater than 14 days at a time. Review of Resident #17's "Psychiatry Progress Note" dated 5/14/25 revealed, "...states that she has had some increased anxiety due to some issues she is working through with staff, but the extra Xanax (sic) during the day helped...Staff report no new or clinically significant changes or concerns with mood or behaviors at this time...Generalized anxiety disorder: moderately stable...Continue Lorazepam 0.5 mg 1 tablet at 4:35 PM PRN anxiety x 30 days. GDR (gradual dose reduction) CI (contraindicated) 4/9/25 as dose continues to be beneficial in controlling ongoing symptoms of anxiety..." No rationale for the medication being written for greater than 14 days.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #17's "Pharmacy Monthly Medication Regimen Review" from June 2025 indicated no irregularities and no new recommendations.			
F0641 SS= D	Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately assess 1 (Resident #70) of 1 resident reviewed for minimum data set (MDS) discharge encoding resulting in inaccurate discharge location data being submitted.	F0641	1. The MDS Nurse appropriately modified and resubmitted the MDS assessment with corrected discharge destination. 2. All residents have the potential to be affected. 3. Bronson Commons MDS RN will double check discharge destination on all assessments prior to signing and submitting to provide a second check of MDS LPN assessments. Policies were reviewed and no necessary updates were identified. 4. The Director of Nursing will complete five weekly audits of discharge location on MDS assessments to ensure accuracy for the next 12 weeks. 5. The Executive Director is responsible for compliance.	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Review of a "Facesheet" revealed Resident #70 was a female who admitted to the facility on 3/8/2025 with pertinent diagnoses which included: weakness and the need for personal assistance. Review of "MDS" for Resident #70 dated 3/19/25 revealed " ...A2000 Discharge Date 3/19/25, A2150 Discharge status, Code entered 04 indicating resident discharged to Short-Term General Hospital. Review of Resident #70's medical record revealed no noted documentation of a transfer from the facility to any hospital. In a telephone interview on 6/11/25 at 2:51 pm "MDS Coordinator" (MDSC) "WW" reported she was the nurse who had completed Resident #70's discharge MDS assessment. MDSC "WW" reviewed the MDS while on the phone and confirmed that she has coded Resident #70 as a short stay hospital discharge (transfer from the facility to the hospital). MDSC "WW" reported that Resident #70 had discharge to home, she had not gone to the hospital. MDSC "WW" reported she had inaccurately coded Resident #70's discharge. In an interview on 6/12/25 "Nursing Home Administrator" (NHA) "A" reviewed Resident #70's discharge MDS with this surveyor and confirmed that Resident #70's discharge MDS was inaccurate. NHA "A" reported "MDS Registered Nurse" (MDS/RN) "Q" was ultimately responsible for the submission of MDS data. NHA "A" stated "MDS/RN "Q" owns the submission information when she signs and submits the information".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 6/12/25 at 11:02 AM- MDS/RN "Q" reported she was the nurse that signed a resident's completed MDS assessments, and her responsibility was to ensure that all areas were completed. MDS/RN "Q" reported she did not review all areas of the MDS assessment for accuracy but did "spot checks" before she submitted it. MDS/RN "Q" reported she did submit Resident #70's discharge MDS assessment a the time of Resident #70's discharge. MDS/RN "Q" did confirm that Resident #70's MDS discharge assessment was inaccurate when it was submitted. MDS/RN "Q" reported the correction report had been created and was waiting to be submitted.			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for 1 residents (Resident #3) of 18 reviewed for the provision of nursing services, resulting in medication not administered following physician ordered parameters, the lack of assessment, and the potential for medication adverse effects and complications Findings include: In an interview on 06/10/25 at 09:27 AM, Resident #3 reported that Registered Nurse (RN) "E" did not listen to her and/or follow the physician orders for her blood pressure	F0658	1. The nurse of the affected resident was provided one-to-one education about the parameters. Nurses will continue to be educated on expectations related to parameters and medication administration. 2. All residents have potential to be affected. 3. Education will be provided to all nurses regarding medication administration expectations for orders with specified parameters. Medication administration expectations related to parameters will be included in new hire orientation. Medication administration policies were reviewed and no necessary updates were identified. 4. Clinical Oversight Committee wil complete five weekly audits of medications with ordered parameters to ensure compliance for the next 12 weeks.	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication. Resident #3 reported that the night before she had tried to tell RN "E" that her blood pressure was too low, and that she should not take her Apresoline (medication used to treat high blood pressure). Resident #3 reported that RN "E" still gave her the medication along with her other medications; Resident #3 felt dizzy and kept her eyes closed for a long time afterwards. In an interview on 06/10/25 at 09:17 AM, Unit Coordinator (UC) "DD" reported that when blood pressure readings are required during medication administration, the nurse would document it in the flowsheet tab of the resident's chart. Review of Resident #3's flowsheets "Blood Pressure" record revealed a result of 112/56 at 5:35 AM on 6/9/25, and there was no record of the resident's blood pressure results in the evening that day. Review of Resident #3's current "Physician Orders" revealed, "Apresoline tablet 25 mg (milligram)...Frequency: 2 times daily...Administration instructions: Hold for SBP (systolic blood pressure: the top number in a reading and represents the pressure in your arteries when your heart beats) less than 130..." Review of Resident #3's Medication Administration Record (MAR) indicated that the first dose of Apresoline was "not given" on 6/9/25 at 8:23 AM, the second dose was "given" by RN "E" at 7:21 PM. In an interview on 06/12/25 at 09:49 AM, Licensed Practical Nurse (LPN) "JJ" reported that Resident #3 knows her medications and remembers her blood pressure results. LPN "JJ" reported that the resident will remind the nurse that her blood pressure was too low, and that she cannot have her blood pressure medication. LPN		5. The Executive Director is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"JJ" reported that 9 times out of 10, they hold the resident's Apresoline due to the top number of her blood pressure being lower than the physician ordered parameters. LPN "JJ" reported that dizziness was a side effect that Resident #3 exhibited when her blood pressure was low. LPN "JJ" reported that there was no documentation of blood pressure being taken prior to the residents's evening dose of Apresoline on 6/9/25, and there was no nursing note indicating that the resident was experiencing dizziness. LPN "JJ" reported that if the Certified Nursing Assistant (CNA) does not report a blood pressure result near the time of medication administration, then the nurse would have to obtain the blood pressure and document verification of a result being within the limits of the physician ordered parameter. In an interview on 06/12/25 at 11:05 AM, RN "E" reported that she normally documented blood pressure results when she administered medication; if there was a blood pressure medication due, the computer would prompt the nurse for the blood pressure and pulse results. RN "E" reported that she administered Resident #3's Apresoline in the evening on 6/9/25. RN "E" reported that a blood pressure of 112/56 would be within the parameters for blood pressure medication to be given, but that she did not remember exactly what Resident #3's blood pressure result was on 6/9/25. In an interview on 06/12/25 at 01:36 PM, Director of Nursing (DON) "B" reported that nurses were expected to verify blood pressure medication parameters with the physician order prior to the administration of the medication and document it. DON "B" reported that the nurse should ensure that the blood pressure is obtained and recorded it in the resident record prior to each dose of medication. DON "B" reported that the computer does not prompt the nurse to obtain or enter a blood pressure result during medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administration, but that it was expected for a nurse to follow the physician order which would require that a blood pressure was obtained prior to the administration of Apresoline. Review of Fundamentals of Nursing (Potter and Perry) 10th edition revealed, "(Nurses) are responsible for documenting any preassessment data required of certain medications such as a blood pressure measurement for antihypertensive (used to treat high blood pressure) medications..." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia A.; Hall, Amy. Fundamentals of Nursing - E-Book (p. 609). Elsevier Health Sciences. Kindle Edition.			
F0679 SS= D	Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide meaningful activities to promote psychosocial well-being for 1 (Resident #42) of 1 resident reviewed for activities. This deficient practice resulted in decreased feelings of connectedness to the community, a lack of meaningful leisure involvement and increased boredom.	F0679	1. Activities staff visited with the resident to update the resident's needs and preferences, and encouraged the resident to express wishes for activities. The resident provided ideas and suggestions that will be implemented. 2. All residents who would like help to plan or participate in activities have the potential to be impacted. 3. The facility reviewed the Patient Activities Assessment policy, assessment tools, and documentation tools, and determined they are appropriate to capture individual resident preferences and participation. The facility reviewed the policy Patient Activities Program and added a quality assurance process to ensure the program meeds the needs of the resident population. Beginning July 2025 the activities calendar will include evening activities and opportunities to serve others. Seasonal outings will begin in August.	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Review of an "Admission Record" revealed Resident #42 was originally admitted to the facility on 10/11/22 with pertinent diagnoses which included: depression (persistent depressed mood or loss of interest in activities causing significant impairment in daily life). Review of a "Minimum Data Set" (MDS) assessment for Resident #42 with a reference date of 10/8/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #42 was cognitively intact. Section "F" revealed it was very important for Resident #42 to choose her bedtime, be around pets, and to participate in her favorite activities. Review of a "Care Plan" for Resident #42 with a reference date of 2/13/23, revealed a problem/goal/interventions of: "Problem: Activities Goal: I will participate in activities I enjoy daily through the next review date. Interventions ...I enjoy participating in group activities that are meaningful to me ...I like dogs, and I might like to visit with pets ...ask me which of my favorite activities are important to keep doing while I am here ...". During an observation on 6/10/25 at 9:29am, Resident #42 was in bed with the curtains pulled and lights off, dressed in sleepwear. In an interview on 6/10/25 at 11:34am, an unknown Certified Nursing Assistant (CNA) emerged from Resident #42's room and reported the resident had just gotten up because she preferred to sleep in/stay up late. In an interview on 6/10/25 at 11:35am, Resident #42 reported the facility was not supporting her involvement in the activities that were of interest		The activities department will audit resident participation monthly to ensure group activities are well attended. At least monthly the activities department will ask residents to evaluate a group activity for opportunities to improve or replace it. Education will be provided to all employees about the right to participate in activities that meet the interests and needs of each resident and how the facility supports these activity pursuits through group and individual programs. The resident council will also receive this education in the July meeting. 4. The activities department will interview five residents monthly to ensure each individual resident is offered activities that are meaningful to them personally, for at least the next 12 weeks. 5. The Executive Director is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to her. Resident #42 stated "I feel like I'm in jail". In an interview on 6/10/25 at 2:51pm, Resident #42 reported she felt the activities program did not meet her needs. Resident #42 reported no group activities were offered in the evening even though she was a "night owl". Resident #42 reported she often felt bored in the evenings. Resident #42 reported it had been difficult to adjust to living at the facility because "it's not my routine/not the things I like". Resident #42 reported she missed her dogs very much and wanted to participate in pet therapy on a regular basis, but it was not offered. Resident #42 described the group activities that were offered as "rinky dink". When further queried, Resident #42 reported the group activities did not support her need to feel like she was making a difference for others and thereby give her a sense of purpose. Resident #42 also reported a lot of the activities seemed too childish for her. Review of "Activity Calendars" for the last 6 months revealed group activities began at 9:30am and ended at 3:30pm each day. Pet Therapy visits were not listed. No community outings were offered. No activities that offered residents to serve others were routinely offered. Review of an "Activity Participation Record" for Resident #42 with a reference date of 5/16-6/05/25, revealed the resident did not participate in pet therapy, community outings or service activities during that period. In an interview on 6/12/25 at 10:01am Activity Director/Nursing Home Administrator (AD/NHA) "A" reported the facility had not provided community outings in many years. AD/NHA "A" reported residents had voiced an interest in pursuing community-based leisure opportunities but unless they had family or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	friends that could take them, the facility had not provided opportunities for community-based leisure involvement. AD/NHA "A" reported the facility had not provided evening activities in the last 5 years and the need to do so had not been assessed "in a few years". AD/NHA "A" reported she was responsible to ensure activities were provided to meet the needs of residents and she was not aware of a need to provide activities in the evenings. AD/NHA "A" reported the activity assistants assessed residents activity needs using only the MDS assessments and she did not routinely review the findings. AD/NHA "A" reported most of the residents who stayed up in the evenings were "loners". When queried about the provision of activities that allow residents to gain a sense of purpose and to serve others, AD/NHA "A" reported the last activity the facility provided in this programming domain was a one-time activity that took place in December 2024. During an observation on 6/12/25 at 10:22am, Resident #42 was in her bed with the curtains closed, lights off. In an interview on 6/12/25 at 11:39am, Resident #42 reported she had not been in the community for any leisure involvement in the last several years. Resident #42 reported she had mentioned her desire to pursue community-based leisure activities, and her need to have purpose in her leisure involvements, but the facility did not provide any support for her to do so. When further queried, Resident #42 stated "The idea of spending the rest of my life in this building is scary. I'd like to contribute to society. You shouldn't have to stop living (when you become a resident) and you should be able to look forward for what else you can do". In an interview on 6/12/25 at 1:43pm, AD/NHA			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"A" reported the resident population of the facility was diverse in needs, abilities and leisure interests. AD/NHA "A" reported it was the responsibility of the facility to ensure the leisure needs of all residents were met. Review of "Participating in Activities You Enjoy as You Age", published by the National Institute on Aging, 3/28/22, revealed: "Research has shown that older adults with an active lifestyle: Are less likely to develop certain diseases. Participating in hobbies and other social activities may lower risk for developing some health problems, including dementia, heart disease, stroke, and some types of cancer ... Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. Doing things that you enjoy may help cultivate those positive feelings ... Studies suggest that older adults who participate in activities they find meaningful, ...say they feel happier and healthier ... When people feel happier and healthier, they are more likely to be resilient, which is our ability to bounce back and recover from difficult situations. Positive emotions, optimism, physical and mental health, and a sense of purpose are all associated with resilience ...research suggests that participating in certain activities, such as those that are mentally stimulating or involve physical activity, may have a positive effect on memory - and the more variety the better...".			
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as	F0689	1. One of the residents had discharged at the time of the survey. The Care plans of the other affected resident was reviewed and updated by the Interdisciplinary Team (IDT). Updated level of assistance and transfer status were shared with clinical teams by leadership to ensure understanding and compliance.	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evidenced by: This citation pertains to Intake MI00151630 Based on observation, interview, and record review, the facility failed to ensure appropriate transfer techniques were implemented for 2 (Resident #172 and #65) of 4 residents reviewed for falls resulting in a fall with a hand laceration and a fracture for Resident #172 and an improper transfer with a slide board resulting in bruising on the bilateral (both) upper arms for Resident #65. Findings include: Resident #172 Review of an "Admission Record" revealed Resident #172 was a female, originally admitted to the facility on 3/11/25. Review of Resident #172's a "Level of Assistance" flowsheet revealed Resident #172 was "limited assistance" for transfer assistance with "Therapy Recommendations" including Front wheeled walker; Wheelchair-manual; Gait Belt; Verbal cues. Review of Resident #172's "Radiology Report" dated 3/16/25 revealed, " ...IMPRESSION: Suspected acute periprosthetic fracture (a break in the bone near an orthopedic implant) is along the distal femoral shaft (lower portion of the thigh bone) associated with the distal intramedullary rod (a surgical implant used to stabilize broken bones) ..." Review of a "Facility Reported Incident" (FRI) "Incident Summary" revealed, "Patient had a witnessed and assisted ground-level fall. She was admitted to (facility name omitted) for physical		2. All residents have potential to be affected. 3. Clinical Oversight Committee will audit care plans to ensure dlear direction and appropriate levels of assistance. Refreshed education to clinical staff where to locate care plan information on EMR devices, and reminded them to always carry these devices to always be ready to verify care plans and assistance levels. Policies were reviewed and no necessary updates were identified. 4. Routine audits of five care plans weekly at Clinical Oversight meetings for clarity of assistance levels Five weekly audits of transfers to ensure the transfer aligns with care plans Five weekly audits of staff demonstrating where to locate care plan information on devices Five weekly audits to devices are on staff members at all times to ensure they are always ready to access the care plan 5. The Executive Director is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and occupational therapy following a previous ground-level fall resulting in a left femur (the bone running from the hip to the knee) fracture requiring surgical repair ...Initial statements reveal that patient was being assisted from the bathroom to the bed by a CNA (certified nurse aide). While standing near the bed, the CNA turned to situate the bedding. The patient let go of the walker and began to fall backwards. The aide immediately reached out and attempted to assist the patient to the floor. Nurse was notified and assessment revealed a laceration to her hand. Neuro (neurological) assessment revealed no concerns. Patient was sent to the hospital for further assessment and repair of the laceration. At that time a left distal femur (lower part of the thigh bone just above the knee) fracture was discovered. CNA was removed from patient care pending investigation ..." Review of Resident #172's Incident/Accident Report/Investigation document provided by the facility revealed, "Patient Interview with (Resident #172) Interview conducted by ("Unit Coordinator" (UC) "R") on 3/19/25 over the phone. (Resident #172) indicated that she was assisted from the bathroom to her bed by an aide. She stated that the girl had hands on her at all times, though a gait belt was not used. When the aide was pulling down the covers, (Resident #172) states she lost her balance and fell ..." Review of Resident #172's Incident/Accident Report/Investigation document provided by the facility revealed, "Interview with (CNA "UU") Interview conducted by ("Director of Nursing" (DON) "B") on 3/17/25. (CNA "UU") answered the bathroom call light and found (Resident #172) on the toilet with her walker in front of her. (Resident #172) stood up independently and proceeded to pull up her undergarments and pants without assistance. (CNA "UU") provided limited assistance to (Resident #172) as she ambulated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	back to the bed. As (CNA "UU") pulled the bedding back, (Resident #172) let go of the walker "to point at the bed control" and began to fall backwards. (CNA "UU") attempted to assist her but was unable to stop her from falling. (DON "B") asked (CNA "UU") if she knew a gait belt was part of (Resident #172)'s care plan and (CNA "UU") admitted she did not. (CNA "UU") shared because (Resident #172) got up from the toilet on her own and managed her undergarments independently, she didn't think to check the care plan to see if a gait belt was needed ..." In an interview on 6/11/25 at 10:11 AM, DON "B", who conducted the interview with CNA "UU" on 3/17/25 reported CNA "UU" had responded to Resident #172's bathroom call light. DON "B" reported CNA "UU" had reported that Resident #172 stood up and was pulling up her own pants and brief and started to walk to the bedroom area. DON "B" reported CNA "UU" had reported she didn't think to put a gait belt on Resident #172. DON "B" reported CNA "UU" had reported she helped Resident #172 to the bed and then went to pull the sheets down and Resident #172 was trying to point to the bed controller and took her hand off the walker and fell. DON "B" reported after the fall, Resident #172 was sent to the hospital and that is when it was found that there was a new acute fracture to her distal femur. DON "B" reported during the interview with CNA "UU", CNA "UU" reported she did not look at the care plan for Resident #172 before the transfer to identify that Resident #172 needed a gait belt. DON "B" reported when CNA "UU" saw Resident #172 stand, CNA "UU" should have asked the resident to sit back down and then look at the care plan and apply the gait belt. DON "B" also reported that in addition to that, CNA "UU" should have, after she put the gait belt on Resident #172, pulled the linens down before Resident #172 was transferred so she didn't have to take that extra step while Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#172 had been standing. Attempts were made to contact Resident #172 during the survey but were unsuccessful. Attempts were made to contact CNA "UU" during the survey but were unsuccessful. Resident #65 Review of a "Facesheet" revealed Resident #65 was a female who was admitted to the facility on 5/14/2025 with pertinent diagnoses which included: Gastroparesis (slow or stopped gastro motility) and dependence for cares. Review of a "Minimum Data Set" (MDS) assessment for Resident #65, with a reference date of 5/20/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 12/15 which indicated Resident #65 was cognitively intact. In an observation and interview on 6/10/25 at 11:43 am, Resident #65 reported that over the weekend, a CNA (certified nurse assistant) did not know how to do a proper slide board transfer for her to use the bathroom and while they transferred her, she received bruises on her inner upper arms. Resident #65 opened her arms and pointed to the upper inside of her left arm where a scattering of bruises was noted. Bruising was noted on the upper inner right arm as well. In an interview on 6/11/25 CNA "Y" reported that Resident #65 was to be transferred with a hoyer lift to the toilet. CNA "Y" reported that Resident #65 was working with therapy using a slide board but had not been upgraded to a slide board transfer to the bathroom yet. CNA "Y" reported that Resident #65 was a slide board transfer from her bed to wheelchair and wheelchair to bed only. CNA "Y" reported Resident #65 had been a hoyer			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transfer to the toilet since she admitted to the facility, CNA "Y" stated "her transfer status had never changed." Review of "Level of Assistance" for Resident #65 revealed "transfer assistance limited assistance; 2 or more person physical assist slide board transfer to/from w/c (wheelchair)>bed. Please continue to use hoyer for toileting ...started on 5/27/2025 12:55 pm ...Toileting Assistance Total dependence; 2 or more person physical assist please use Hoyer for toilet transfers ...started on 5/27/2025 at 12:55 pm ...Therapy Recommendations wheelchair-manual; gait belt; slide board ... stated 5/27/2025 12:55 pm." In an interview on 6/11/25 at 12:43 pm CNA "I" and CNA "PP" reported that Resident #65 was slide board transfer between bed and wheelchair, and a hoyer transfer to the toilet. CNA "PP" reported that Resident #65's care plan; level of assistance was how the CNAs knew how she transferred. In an interview on 6/11/25 at 2:23 pm, CNA "Y" reported that Resident #65 had reported to her on Monday 6/9/25 that staff was transferring her some time over the weekend with a slid board to the toilet, staff had gotten impatient with using the slide board and then did a stand and pivot transfer to the toilet. CNA "Y" reported that Resident #65 reported to her the transfers were what had caused the bruising on her inner arms. CNA "Y" reported she saw the bruising on Resident #65's inner arms. CNA "Y" reported she reported the bruising and the Resident #65's account of what happened to "Registered Nurse" (RN) "MM". In an observation and interview on 6/11/25 at 2:27 pm, Resident #65 reported she was a slide board transfer from bed to wheelchair or back and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that she was a hoyer transfer to the toilet. Resident #65 reported that two girls were transferring her over the weekend and were using the slide board, when they got impatient with how long it was taking her to get her onto the toilet, and that the girls then decided to pick her up and transfer her to the toilet. Resident #65 reported her thought that was when her arms were bruised. Resident #65 lifted her left arm to show this surveyor the bruising that was still present on her inner upper left arm. There was a scattering of bruising noted. In an interview on 6/12/25 at 9:20 am "Physical Therapy Assistant" (PTA) "BBB" reported that Resident #65 reported to her on Monday 6/6/25 in the morning, that the aides instead of using the hoyer lift to transfer her onto the toilet, one aide said "I don't have time to use the hoyer or the slide board, and Resident #65 reported the aides just picked her up and put her in the chair and then again picked her up to put her onto the toilet. PTA "BBB" reported she observed bruising noted on the inner upper arms of Resident #65. PTA "BBB" reported that Resident #65 was a hoyer lift transfer to the toilet. In an interview on 6/12/25 at 10:37am, "Unit Coordinator" (UC) "R" reported that she had spoken to Resident #65 and that she had noted the bruising on her inner upper arms with the bruising being greater on the left. UM "R" reported that Resident #65 should be a hoyer lift transfer to the toilet, and she believed the bruising was from a slide board transfer. UM "R" reported she had not yet interviewed any staff that worked over the weekend to determine any details of the situation during the transfer with Resident #65. In an interview on 6/12/25 at 10:45 am, "Nursing Home Administrator" (NHA) "A" reported she was aware of the bruising with Resident #65 and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her expectations were that her leadership team would conduct an investigation to try to understand the event fully. NHA "A" reported that there was concern that Resident #65's care plan was not followed, and she was transferred incorrectly, and that staff would need further education. In a telephone interview on 6/12/25 at 11:16 am, CNA "P" reported that she did complete a slide board transfer with Resident #65 from the wheelchair to the toilet on Friday. CNA "P" reported that she believed that Resident #65's transfer status had changed from a hoyer lift to slide board. CNA "P" stated that she did assist Resident #65 with a gait belt into a standing position with another CNA present to assist pulling up Resident #65's pants. CNA "P" reported she did not complete a stand a pivot transfer with Resident #65. CNA "P" reported that she had since been reeducated by the leadership nurses on how Resident #65 transferred. CNA "P" reported that she had been contacted by the facility and asked about the bruising to Resident #65's arms, and CNA "P" reported she did not see any bruising until Resident #65 showed her on Monday. In a telephone interview on 6/12/25 at 1:31 pm, CNA "ZZ" reported she was assigned to work with Resident #65 on a night over the weekend. CNA "ZZ" reported that she did not perform a transfer with Resident #65, she was working alone, and when Resident #65 asked to use the bathroom during her shift, she reported that she told Resident #65 that she did not have time to use the slide board or the hoyer to transfer her and CNA "ZZ" reported she offered her the use of a bed pan. CNA "ZZ" reported that she was told by the CNAs that worked the shift her over the weekend that Resident #65 was now a slide board transfer. CNA "ZZ" reported she was reeducated last night on Resident #65's transfer status.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure one out of five residents (Resident #26) had water available at the bedside, resulting in the potential for dehydration. Findings include: Review of an "Admission Record" revealed Resident #26 was originally admitted to the facility on 2/16/29 with pertinent diagnoses which included: alzheimer's disease (a progressive disease that primarily affects memory, thinking and behavior) and renal insufficiency (disease in which the kidneys lost the ability to remove waster and balance fluids).	F0692	1. Corrective action took place immediately upon identification of the issue by moving the water within the resident's reach. 2. All residents have the potential to be affected. 3. Education to all staff related to ensuring water is within patient reach at all times in the resident's room. Policies were updated to reflect that water must be within the resident's reach in their room: Water Pass policy, TEMP Purposeful Rounding policy. 4. Five weekly audits of water location within resident's reach in their room wil be completed for the next 12 weeks. 5. The Executive Director is responsible for compliance.	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a "Minimum Data Set" (MDS) assessment for Resident #26 with a reference date of 6/4/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 3/15 which indicated Resident #26 was severely cognitively impaired. Review of a "Care Plan" for Resident #26 with a reference date of 9/25/19, revealed a problem/goal/interventions of: 1. "Problem: Nutritional Status. Goal: My nutritional needs will be met through the next review. Interventions: Please give me my diet as ordered ...monitor my food acceptance. 2. Problem: ADLs (Activities of Daily Living). Goal: I will accept assistance with care needs ...Interventions: I have a self-care deficit related to weakness ...". Review of a "Fluid Intake Report" for Resident #26 with a reference date of 5/13-6/11/25, revealed the resident drank less than 720 milliliters(ml) per day during that period. During an observation on 6/10/25 at 11:04am, Resident #26 was assisted from her restroom to her bed by Certified Nursing Assistant (CNA) "UU". During an observation and interview on 6/10/25 at 11:05am, Resident #26 laid in her bed on her back. A large covered maroon cup was stored on the sink counter, approximately 8' from the resident. No other beverage was present in Resident #26's room. The resident's lips appeared dry and stuck to her dentures when she spoke. Resident #26 reported she was thirsty. During an observation on 6/11/25 at 11:14am, Resident #26 laid on her back in bed in her room. The resident's maroon water cup was stored on the sink counter, across the room. The bedside table was the foot of her bed. No other beverage			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was present. An unidentified CNA, entered the room, looked at Resident #26 and left the room. During an observation on 6/11/25 at 11:25am, Resident #26 was asleep in bed. The bedside table was next to her bed with nothing on it. The maroon water cup remained on the sink counter, across the room. During an observation on 6/11/25 at 11:58am, Resident #26 laid on her back in bed. The resident's maroon water cup was stored on the sink counter, across the room. During observations on 6/11/25 at 2:32pm and 3:44pm, Resident #26 laid on her back in bed. The resident's maroon water cup was stored on the sink counter, across the room. The bedside table was at the foot of her bed and no beverages were present in the room. In an interview on 6/11/25 at 3:46pm, Licensed Practical Nurse (LPN) "HHH" reported the expectation was for CNA's to ensure the resident has their call light and water within reach before leaving the room. In an interview on 6/12/25, at 9:16am, CNA "J" reported Resident #26 should have her water within reach when she is in her room. CNA "J" reported the facility provided maroon drinking cups for every resident and the nursing staff filled the cups at the beginning of each shift at a minimum. CNA "J" reported some residents who were weak had difficulty holding the maroon cup, including Resident #26, and should be provided a smaller, clear cup with a lid. In an interview on 6/12/25, at 9:22am, LPN "C" reported potential complications that could result from a resident being dehydrated included: urinary tract infections, confusion and falls. LPN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"C" reported fresh water should be kept at the resident's bedside and replenished every shift at a minimum. LPN "C" reported the facility provided large maroon, covered water cups for every resident. LPN "C" reported any staff member that enters a resident's room was expected to ensure the resident's water, call light and belongings were in reach before exiting the room. LPN "C" reported Resident #26 was not on a fluid restriction. Review of a "Water Pass" policy with no reference date revealed "POLICY: Due to the risk of dehydration (and other health concerns) and for patient comfort (weather related), fresh water must be available 24 hours per day ...PROCEDURE: ...CNA provides fresh ice water mug to each patient ...".			
F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i)	F0880	1. The Infection Prevention Nurse provided one-to-one education on enhanced barrier precautions (EBP) with the resident's nurse. 2. All residents have the potential to be affected if they meet criteria for EBP. 3. Education will be provided to clinical employees related to EBP standard work. The following policies were updated to include verbiage related to using the appropriate personal protective equipment (PPE) as ordered, including EBP: Enteral Feeding, Indwelling Catheter, Peripherally Inserted Central Catheter Change, Irrigating Foley Catheter, Peripheral Intravenous Therapy Procedure, Male Straight Catheter, Female Straight Catheter, Care-Cleaning Urinary Drainage Bags, Pressure Injuries and Wound Care, Wound Culture. 4. Five weekly audits wil be completed by the	7/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that enhanced barrier precautions (EBP) were maintained during tube feeding administration for 1 (Resident #21) of 1 resident reviewed for tube feeding administration resulting in the potential for		Infection Prevention Nurse or designee to ensure compliance with using EBP when appropriate, for the next 12 weeks. 5. The Executive Director is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	introduction of infection, cross-contamination, and disease transmission. Findings include: Review of a "Facesheet" revealed Resident #21 was a female who had admitted to the facility on 7/25/24 with pertinent diagnoses which included: cardiovascular accident (CVA/Stroke) and PEG (percutaneous gastrostomy tube/feeding tube). During an observation on 6/10/25 at 11:55 am, outside of Resident #21's room was a sign posted on the door frame indicating that the resident was in enhanced barrier precautions. Review of "Physician Orders" for Resident #21 revealed " ...diet order NPO (nothing by mouth) ordered 8/16/2024 ...Isosource 1.5 bolus (single administration, all at one time) feed oral liquid 250mL (milliliters) via feeding tube four times a day started 12/20/2024 ...Free water 250 mL via tube feeding five times a day with a start date of 12/20/2024 ..." Review of "Care Plan" for Resident #21 revealed " ...Problem ...ADLs (activities of daily living) interventions included enhanced barrier precautions ...with a start date of 7/25/2024 ...Problem ...I require enteral feeding and I'm at risk for complications ...with a start dated of 9/5/2024 ..." During an observation and interview on 6/11/25 at 12:14 pm, "Licensed Practical Nurse" (LPN) "JJ" entered Resident #21's room and administered a bolus feeding through Resident #21's feeding tube. LPN "JJ" did not wear a gown during the administration of Resident #21's bolus feeding. LPN "JJ" reported that the signage on the door indicating Resident #21 was in enhanced barrier precautions was for the CNAs (certified			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	6/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	23332 RED ARROW HIGHWAY MATTAWAN, MI 49071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nursing assistants) to wear a gown and gloves when they were coming in contact with the resident's feeding tube. LPN "JJ" stated "I get lucky since I don't actually come in contact with her feeding tube, I don't have to do anything with it (EBP sic) at all. In an interview on 6/12/25 at 12:10 pm, "Registered Nurse" (RN) "RR" reported that EBP were not used for administration of feeding through a feeding tube. In an interview on 6/12/25 at 12:20 pm, LPN "C" reported that when administering a bolus feeding through a feeding tube the nurse would need to wear a gown, and gloves as indicated for EBP. In an interview on 6/12/25 at 12:25 pm, "Certified Nurse Assistant" (CNA) "UU" reported she did not administer any tube feedings to resident, and that EBP did no apply to her. In a telephone interview on 6/12/25 at 1:03 pm "Unit Coordinator" (UC) "S" reported that EBP (wearing a gown and gloves) should be used when administering a feeding through a feeding tube for a resident. Review of a facility policy "Enhanced Barrier Precautions Standard Work" undated and provided by the facility revealed " ...purpose: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed it reduce transmission of multidrug-resistant organism (MDRO) that includes gown and gloves use during high contact resident care ...1. All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions ... EBP will be implemented for resident with any of the following: b. indwelling medical devices ...feeding tube ...implementation of EBP: PPE			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	804040	A. BUILDING _____ B. WING _____	**6/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONSON COMMONS	**23332 RED ARROW HIGHWAY MATTAWAN, MI 49071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(personal protective equipment) for EBP is only necessary when performing high-contact care ...device care or use ...feeding tube ..."			